

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

05070

Reg. Dist. No. 492

### 1. PLACE OF DEATH:

County Harford  
City or town Dublin - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 yrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Harford  
City or town Dublin - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Ellis P. Anderson

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced m

6. (b) Name of husband or wife Ginny Anderson

7. Birth date of deceased (mo., day, yr.) July 28, 1875 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 71 Months 10 Days 15 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Grayson Co., Va.  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Robert Anderson

12. Name Robert Anderson

13. Birthplace Grayson Co., Va.

14. Maiden name Antonia Perkins

15. Birthplace Va.

16. Informant Mrs. Ginny Anderson

Address Street, Harford Co. Md.

17. (Burial, cremation, or removal, which?) Burial Date thereof June 15, 1947  
(month) (day) (year)

Cemetery or crematorium Oak Grove

Location Churchville, Md.

18. Funeral director W. A. Patterson & Son

Address Terryville, Md.

19. June 14, 1947 M. D. W. H. Hilde  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 47 at 10.10 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 19 47 to June 12 19 47 and that I last saw him alive on June 10 19 47

Immediate cause of death Terminal Broncho pneumonia DURATION 2 days

Due to Senility

Due to \_\_\_\_\_

Other conditions Parkinsonism

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dudley Phillips MD M. D. or other \_\_\_\_\_  
Address Darlington, Md Date signed 6/13/47

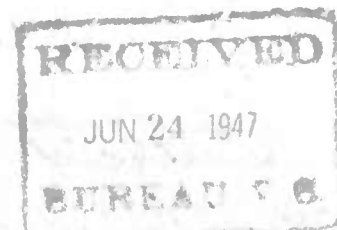
MARGIN RESERVED FOR BINDING

I

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



*on file*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 158

## CERTIFICATE OF DEATH

05071

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County HarfordCity or town Home for Grace  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 hrs

Hospital, institution, or street address where death occurred:

Harford Mem. Hospital - Harford, Md.How long in hospital or institution? 9 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Port Deposit  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Baby Girl Arthur

## 3. (b) Social Security Number

## 4. Sex

F.

## 5. Color or race

W.6. (a) ☒ Single ☐ married, widowed, or divorced

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

## 8. AGE:

Years

Months

Days

If less than one day

9 hrs.

min.

## 9. Birthplace

Home de Grace, Harford, Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. (Burial, cremation, or removal, which)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

19. June 5

## Date rec'd by registrar

19. 47

## Date

## Registrar

## Address

## Date signed

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 5/47 1954 at 10 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5/47 - 10 AM 1954 to same 1954 and that I last saw him alive on June 5/47 - 10 AM 1954

## Immediate cause of death

Anoxia and respiratory depression

## DURATION

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

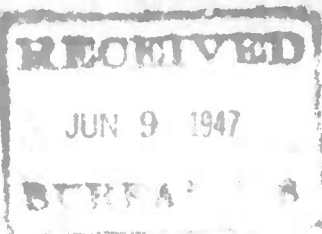
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

John F. Noguera MD  
M. D. or other \_\_\_\_\_  
Address Harford Mem Hospital Date signed 6/5/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05072

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

## 1. PLACE OF DEATH:

County Harford  
 City or town Abingdon  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Abingdon  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Annie Bell

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 10, 1861  
 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
85 10  
 hrs. min.

9. Birthplace Baltimore, Maryland  
 (Town, county and state)

10. Usual occupation None

11. Industry or business

12. Name Edward J. Bell13. Birthplace Baltimore Md14. Maiden name Sarah E. Dutton15. Birthplace Baltimore Md16. Informant Miss Jennie M. BellAddress Abingdon Maryland

17. Burial Date thereof June 12, 1947  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. John'sLocation Kingsville Balt. Co. Md18. Funeral director Howard K. McCannanAddress Abingdon Maryland19. June 12 19 47 Maryland Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 47, at 5:00 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 47, to June 19 47and that I last saw him alive on June 9 19 47Immediate cause of death Heart Failure

DURATION

Due to Hypertensive cardio  
vascular disease 5 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE GB Jastram MD M. D. or otherAddress Aberdeen Md Date signed 6/11/47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 16 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

## CERTIFICATE OF DEATH

05073

Reg. Dist. No. 186-

## 1. PLACE OF DEATH:

County..... Harford  
 City or town..... Rural, Havre De Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 yr. 7 Months  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford  
 City or town..... Rural Havre De Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Judith Marie Bines

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... Nov 24, 1943  
 8. AGE: Years..... 3 Months..... 6 Days..... 23 If less than one day..... hrs. .... min.

9. Birthplace..... Perryville, Cecil Co., Md.  
 (Town, county, and state)

## 10. Usual occupation.....

## 11. Industry or business.....

FATHER 12. Name..... Roland Bines  
 13. Birthplace..... Cecil Co., Md.  
 MOTHER 14. Maiden name..... Mabel Burns  
 15. Birthplace..... West Chester, Pa.

16. Informant..... Benjamin Burns  
 Address..... Havre De Grace, Md. R D.

17. Burial Date thereof..... June 19, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... West Nottingham  
 Location..... Colora, Md. Rural

18. Funeral director..... Lee A. Patterson & Son  
 Address..... Perryville, Md.

19. June 18 19 47 A. L. Lewis Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 16 19 47 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 19 47 to June 16 19 47 and that I last saw him alive on June 16 19 47

Immediate cause of death..... Epilepsy  
epilepsy  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

## DURATION

5 hrs  
uninterrupted

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... J. F. Mayhew  
 M. D. or other.....  
 Address..... Perryville, Md. Date signed..... 6/18/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

## 1. PLACE OF DEATH:

County Harford  
 City or town Army Chemical Ctr., Edgewood  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
Station Hospital  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Army Chemical Center, Edgewood  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

FLORENCE WILSON BYROADE

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife George L. Byroade  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) November 18, 1871  
 8. AGE: Years 75 Months 7 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Johnstown, Penna.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

FATHER 12. Name Joseph T. Wilson

13. Birthplace McKees Rock, Penna.

MOTHER 14. Maiden name Elizabeth Etchison

15. Birthplace Frederick, Maryland

16. Informant Major George L. Byroade, Jr.

Address Army Chemical Center, Md.

17. Burial Date thereof June 30, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory National Cemetery

Location Arlington, Virginia

18. Funeral director Howard R. McBurnison

Address Abingdon Maryland

19. June 30 19 47 M. M. Monkdale  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 25 June 1947 xx at 9:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 June 19 47 to 25 June 19 47

and that I last saw her alive on 25 June 19 47

Immediate cause of death Left ventricular failure; terminal pneumonia

## DURATION

Due to Arterio-sclerotic cardiovascular disease.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William B. Marbury, Jr. M. D. or other

Address Army Cml Ctr., Md. Date signed 26 June 47

CERTIFICATE OF DEATH

RECEIVED

JUL 1 1947

BUREAU F.R.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

05075

93d

## 1. PLACE OF DEATH:

County Harford  
 City or town Harre de Chase  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs  
 Hospital, institution, street address where death occurred:

St. Francis Villa

How long in hospital or institution? 2 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town Harre de Chase  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Commerce & Market  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sister Mary Rosina (Pauline Daiber)

## 3. (b) Social Security Number

-

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

## 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1/31/1866 6.(c) If alive, give age, years

8. AGE: Years 81 Months 4 Days 23 If less than one day: hrs. min.

9. Birthplace Germany  
 (Town, county, and state)

10. Usual occupation Teacher

## 11. Industry or business

12. Name Mathias Daiber

13. Birthplace Germany

14. Maiden name Pauline Daiber

15. Birthplace Germany

16. Informant Frank Peters

Address Commerce & Market

17. Burial Date thereof 6/25/47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

18. Funeral director Bennish & Son

Address Harre de Chase, Md

June 25 19 47 A. L. Lewis, Jr.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 19 47 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 46 to June 23 19 47  
 and that I last saw him alive on June 23 19 47

Immediate cause of death

Chronic Myocarditis  
Cerebral Hemorrhage

Due to Chronic Myocarditis  
 Due to Cerebral Hemorrhage

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

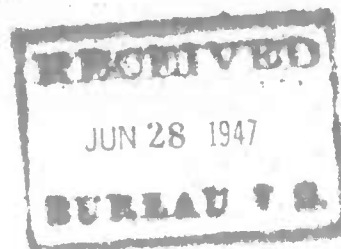
Charles J. Foley, M.D.  
 Address Harre de Chase, Md Date signed June 25

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

## CERTIFICATE OF DEATH

05076

Reg. Dist. No. 185

### 1. PLACE OF DEATH:

County Harford  
City or town Darlington  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Harford Memorial Hosp  
How long in hospital or institution? 9 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Harford  
City or town Darlington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Mrs. Mary Day

### 3. (b) Social Security Number

No

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Wid.

6. (b) Name of husband L. C. Day

7. Birth date of deceased (mo., day, yr.) March 9, 1867 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 80 Months 3 Days 2 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Harford Co. Md.  
Town, county, and state

10. Usual occupation Housework

11. Industry or business at home

12. Name J. J. Warner

13. Birthplace Harford Co. Md.

14. Maiden name Althia Scarborough

15. Birthplace Harford Co. Md.

16. Informant Mrs. Odessa C. Murphy Jr.

Address Darlington, Md.

17. Burial Burial Date thereof June 13, 1947  
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematorium Darlington Cem

Location Harford Co., Md.

18. Funeral director H. J. Bailey

Address Darlington, Md.

Date rec'd by registrar June 12, 1947 Registrar H. L. Lewis, Jr.

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-2-47 to 6-11-47

and that I last saw her alive on 6-11-47

Immediate cause of death Cerebral vascular accident DURATION \_\_\_\_\_

Due to Hypertensive Cardio-vascular disease

Due to \_\_\_\_\_

Other conditions Fractured left femur

(Include pregnancy within 3 months of death)

Major findings of operations Fractured neck of left femur

Date of op. 6/4/47

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? Darlington (City or town) MD (County) (State)

Injured at home, farm, industry, public place (where?) patient's home  
Means of injury slipped over a stool in her bedroom Injured at work? \_\_\_\_\_

Signature John F. Noguera MD M. D. or other \_\_\_\_\_  
Address Harford Mem Hosp. Date signed 6/11/47

MARGIN RESERVED FOR BINDING.

I

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HM  
I

RECEIVED  
JUN 14 1947  
BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

65077

## 1. PLACE OF DEATH:

County... HarfordCity or town... Harford  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... HarfordCity or town... Harford  
(If outside city or town limits, write RURAL and give nearest town)Street No. 235 St. John  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Emma M. Gallion

## 3. (b) Social Security Number

-

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife George W. Gallion7. Birth date of deceased (mo., day, yr.) 12/9/18758. AGE: Years 71 Months 6 Days 15 If less than one day hrs. min.9. Birthplace Newark N. J.  
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name Thomas M. Rhinney13. Birthplace Ireland14. Maiden name Emma M. Cody15. Birthplace Newark N. J.16. Informant George W. Gallion (Husb.)Address 235 St. John17. Burial Date thereof 6/18/47  
(Burial, cremation, or removal. Which?) (Month) (day) (year)Cemetery or crematory Walden ChapelLocation near Harford Chase19. Funeral director Pennington & SonAddress Harford Chase19. June 17 19 47 A. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 15-47 at 4:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 19 47 to June 15 19 47 and that I last saw him alive on June 15 19 47

Immediate cause of death

Chronic CoronaryMyocardial InfarctionDue to Chronic CoronaryMyocardial Infarction

Due to

Other conditions Torpidity

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Feltz M.D.Address 1st St. & Broad St. Date signed 6/14/47

RECEIVED  
JUN 18 1947  
BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No.

05078  
180

## 1. PLACE OF DEATH:

County HarfordCity or town Joppa  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Joppa  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Christina Harden

## 3. (b) Social Security Number

220-20-70314. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife John W. Harden7. Birth date of deceased (mo., day, yr.) Mar 3, 1893 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 54 Months 3 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Woodsboro, Maryland  
(Town, county, and state)10. Usual occupation Retired Govt. Employee

11. Industry or business \_\_\_\_\_

12. Name Phillip Keeney13. Birthplace Maryland14. Maiden name Ann Smith15. Birthplace Maryland16. Informant John W. HardenAddress Joppa, Maryland17. Burial Date thereof June 23, 1947  
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory Mt. PleasantLocation Sam's Grove, Maryland18. Funeral director Howard K. McShayonAddress Abingdon, Maryland19. June 23, 1947 Maureen Monksdale  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1947 at 1 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12, 1947 to June 20, 1947 and that I last saw him alive on June 20, 1947Immediate cause of death Cerebral Hemorrhage DURATION 3 hrs.Due to Hypertensive Cardiovascular Dis. 1 yr.Due to Conjunctive Heart Failure 3 mos.Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature Clifford F. Hudson, M.D. M. D. or other \_\_\_\_\_Address Fork, Md. Date signed 6/21/47

RECEIVED  
JUN 25 1947  
BUREAU V B.

RAO CONTENT

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County HarfordCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)Street No. 711 Lewis

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

WALTER H. HIPKINS

## 3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Oliver G. Hipkins6. (c) If alive, give age 41 years7. Birth date of deceased (mo., day, yr.) May 10 - 19038. AGE: Years 44 Months 1 Days 4 If less than one day  
hrs. min.9. Birthplace Aberdeen  
(Town, county, and state)10. Usual occupation Auto Mechanic

11. Industry or business

12. Name John Hipkins13. Birthplace Aberdeen14. Maiden name Preston15. Birthplace Aberdeen16. Informant Mrs. Oliver G. Hipkins (wife)Address 711 Lewis St. Harford17. Burial Date thereof 6/17/47  
(Burial, cremation, or removal, Which) (month) (day) (year)Cemetery or crematory Wesleyan ChapelLocation near Harford18. Funeral director Pennington & SonsAddress Harford Md.19. June 16 1947 Q. L. Lewis  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 14 1947 at 9:20 P.M.

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from

and that I last saw him alive on June 14 1947Immediate cause of death ACCIDENTAL DROWNING

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT Date of JUNE 14, 1947Where did injury occur? HARFORD (City or town) MD. (County) (State)Injured at home, farm, industry, public place (where?) SUSQUEHANNA RIVERMeans of Injury Fall off Boat Injured at work? No23. SIGNATURE Jordan M.D.Address Aberdeen Md. Date signed 6/15/47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED  
JUN 18 1947  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

CB 05080

181

## 1. PLACE OF DEATH:

County... Harford  
 City or town... Abertdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 days  
 Hospital, institution, or street address where death occurred:  
619 E. Bel Air Ave.  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Illinois County...  
 City or town... Granston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 2601 Central St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... none ✓

## 3. (a) FULL NAME

Lennie L. Houston

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Richard W. Houston

## 7. Birth date of deceased (mo., day, yr.)

May 8th 1866

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

811

..... hrs.

..... min.

## 9. Birthplace

Baltimore Md.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER

## 12. Name

William W. Chase

## 13. Birthplace

Baltimore Md.

## 14. Maiden name

Sarah T. Stanford

## 15. Birthplace

Baltimore Md.

## 16. Informant

Mrs. Terian W. Evans

## Address

1915 Hilford Ave. Balto. Md.

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

July 1 - 1947  
(month) (day) (year)

## Cemetery or crematory

Baltimore

## Location

Baltimore Md.

## 18. Funeral director

Henry Tarrington Sons

## Address

Abertdeen Md.

## 19.

June 30 47  
(Date rec'd by registrar)47Nellie A. Wiley  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 29th 1947 at 11:00 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 26 1947 to June 27 1947

## and that I last saw him/her alive on

June 27 1947

## Immediate cause of death

acute congestive heart failure

## DURATION

acute congestive heart failure 2 yearsDue to Coronary Thrombosis

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

## Major findings of operations

..... Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

## Means of injury

Injured at work?

## 23. SIGNATURE

W. A. Dulaney M.D.

M. D. or other

Address... Abertdeen Md. Date signed 6/30/47

RECEIVED  
JUL 5 1947  
BUREAU OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05081

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Harford

City or town Cardiff

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Cardiff

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

D. Francis Jones

## 3. (b) Social Security Number

217-01-0845

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Anna E. Jones

6. (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) April 24, 1888

8. AGE: Years 59 Months 1 Days 22 If less than one day

9. Birthplace Harford Co. Md.

(Town, county, and state)

10. Usual occupation Quarryman

11. Industry or business

12. Name Samuel J. Jones

13. Birthplace Harford Co. Md.

14. Maiden name Ida Henry

15. Birthplace Harford Co. Md.

16. Informant Mrs. Anna E. Jones

Address Cardiff, Md.

17. Burial Date thereof June 19, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Slate Ridge cemetery

Location Delta, Pa.

18. Funeral director Hubert P. Harkins

Address Delta, Pa.

19. June 18, 1947 M. V. Kirk

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 16 1947 to June 16 1947

and that I last saw him alive on June 16 1947

Immediate cause of death

Coronary Thrombosis

DURATION

Due to Coronary sclerosis 7 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. A. Hunt, M.D.

M. D. or other

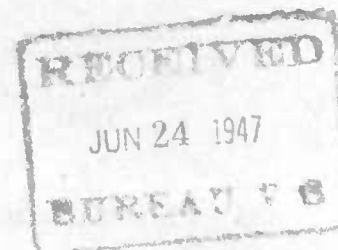
Address Delta Pa. Date signed 6/17/47

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1570

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

05082

### 1. PLACE OF DEATH:

County Harford  
City or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 days  
Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
How long in hospital or institution? 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Harford  
City or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 608 Revolution St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Mary P. Mitchell

### 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced S.

6.(b) Name of husband or wife 6-30-46 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 5

8. AGE: Years 11 Months 3 Days — If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Harre de Grace, Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Robert Otto Mitchell  
13. Birthplace Md.

14. Maiden name Lillian Thompson  
15. Birthplace Md.

16. Informant Mrs. Lillian Mitchell  
Address Harre de Grace, Md. Box 112

17. Burial Date thereof June 24, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Angel Hill

Location Harre de Grace

18. Funeral director R. Madison Mitchell  
Address Harre de Grace, Md.

19. June 4 19 48 A. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 2<sup>nd</sup> 1948 at 6:02 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-30-47 19, to 6-2-47 19, and that I last saw him alive on 6-2-47 19.

Immediate cause of death Bronchopneumonia

Due to Upper Resp. Infection

Due to \_\_\_\_\_

Other conditions Hydrocephalus

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John F. Noguera MD  
M. D. or other \_\_\_\_\_  
Address Harford Mem Hosp. Date signed 6-2-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 6 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05083

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Forest HillCity or town Forest Hill  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Samuel O. Nagle

## 3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Margaret A. Nagle

7. Birth date of

deceased (mo., day, yr.) April 8, 1858

8. AGE:

Years 89Months 2Days 14

If less than one day

hrs.

min.

8. Birthplace Forest Hill, Md.  
(Town, county, and state)10. Usual occupation Retired Brick Layer11. Industry or business Building12. Name Samuel O. Nagle13. Birthplace Forest Hill, Md.14. Maiden name Elizabeth Brown15. Birthplace Forest Hill, Md.16. Informant Anna M. NagleAddress Forest Hill, Md.17. Buried

(Burial, cremation, or removal. Which?)

Date thereof June 25, 1947  
(month) (day) (year)Cemetery or crematory BuriedLocation Forest Hill, Md.18. Funeral director Howard WebbAddress Forest Hill, Pa.19. 6/27 19 47 Priscilla Lowm  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County HarfordCity or town Forest Hill, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 19 47, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 1 -1947, to June 25 19 47and that I last saw him alive on June 25 19 47Immediate cause of death Lobar pneumonia

DURATION

3 daysDue to TerminatingChr. Prostetic lesion

Due to

Other conditions Chr. myocardial lesionGen. arteriosclerosis  
(Include pregnancy within 3 months of death)3 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

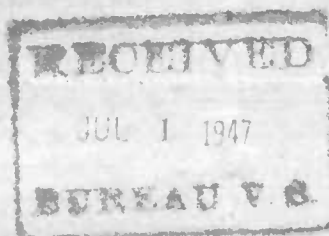
Means of injury

Injured at work?

23. SIGNATURE Willard P. Hudson

M. D. or other

Address Forest Hill, Md.Date signed 6/25/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

05084

## 1. PLACE OF DEATH:

County HarfordCity or town Belt Air Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Belt Air Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Margie J. Norman

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife Matthew Norman7. Birth date of deceased (mo., day, yr.) July 2, 1865 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 81 Months 11 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Hayson Ct. Va  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Thomas B. Hampton13. Birthplace Virginia14. Maiden name Justin Collins15. Birthplace Virginia16. Informant Ralph J. NormanAddress Belt Air Maryland17. Burial Date thereof June 17, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. ZionLocation Freemantle Green Md18. Funeral director Howard R. McCombsAddress Abingdon Maryland19. 6/16 47 Priscilla Lownd  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sun June 15 19 47, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 30, to June 19 47and that I last saw h. at alive on June 14 19 47Immediate cause of death myocardial failure DURATIONDue to Atherosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Protonk M DAddress Belt Air Md M. D. or other \_\_\_\_\_Date signed 6/17/47

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JUN 24 1947

BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

## CERTIFICATE OF DEATH

05085

Reg. Dist. No. 186

### 1. PLACE OF DEATH:

County Harford  
City or town Harford  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 76 yrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Harford  
City or town Harford  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 225 N. Washington  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

George Thompson Pennington

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Mary M. Pennington 6.(c) If alive, give age 73 years  
7. Birth date of deceased (mo., day, yr.) April 15 - 1871  
8. AGE: Years 76 Months 7 Days 23 If less than one day  
hrs. min.

9. Birthplace Harford  
(Town, county, and state)

10. Usual occupation Funeral Director & Embalmer

### 11. Industry or business

12. Name Joseph A. Pennington  
13. Birthplace Harford

14. Maiden name Bedelia Hollahan

15. Birthplace Harford

16. Informant Robert Pennington

Address Harford

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 6/10/47  
(month) (day) (year)

Cemetery or crematory Angel Hill

Location Harford

18. Funeral director Geo. R. Beyer Jr

Address 1512 Hollin St Balto. Md

19. 6-9 19 47 C. L. Lewis Jr. D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 47 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 47 to June 7 19 47

and that I last saw him alive on June 7 19 47

Immediate cause of death Arterio Sclerosis

Hypertension

Due to Cerebral Hemorrhage

Due to

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D. M. D. or other

Address Harford Date signed June 6/1947

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 12 1947

SECRET

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 186-

## 1. PLACE OF DEATH:

County Harford  
 City or town Harvre de Grace  
 (if outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 days  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
 How long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford  
 City or town Darlington, Md.  
 (if outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION) No  
 2.(d) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOHN F. RHOADES

## 3. (b) Social Security Number

280-03-4066 A

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Anna C Rhoder</u>		
7. Birth date of deceased (mo., day, yr.) <u>Feb. 17, 1882</u>		
6. (c) If alive, give age _____ years		
8. AGE: <u>65</u> Years <u>3</u> Months <u>14</u> Days	If less than one day _____ hrs. _____ min.	
9. Birthplace <u>Rockland Maine</u> (Town, county, and state)		
10. Usual occupation <u>Retired</u>		
11. Industry or business <u>Engineer</u>		
12. Name <u>Daniel Rhoder</u>		
13. Birthplace <u>Rockland Maine</u>		
14. Maiden name <u>Elizabeth Cleveland</u>		
15. Birthplace <u>Rockland Maine</u>		
16. Informant <u>Mrs Anna Rhoder</u>		
Address <u>Darlington, Md.</u>		
17. <u>Burial</u> Date thereof <u>June 3, 1947</u> (Burial, cremation, or removal, which?) (month) (day) (year)		
Cemetery or place of interment <u>Darlington Cem</u>		
Location <u>Harford Co., Md.</u>		
18. Funeral director <u>H. S. Bailey</u>		
Address <u>Darlington Md.</u>		
19. <u>June 1, 1945</u> Date rec'd by registrar <u>A. L. Lewis m. d.</u> Registrar		

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st. 19 47 at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 19 47 to June 1st 19 47 and that I last saw him alive on May 31st 19 47

Immediate cause of death Recurrent cerebral thromboses

Due to Hypertensive cardiovascular disease

Due to \_\_\_\_\_

Other conditions Paraplegia

(Include pregnancy within 3 months of death)

Major findings and operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John F. Noguera m.d. M. D. or other \_\_\_\_\_

Address Harford Mem Hosp Date signed 6/1/47

RECEIVED

JUN 6 1947

BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

## CERTIFICATE OF DEATH

05087

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Harford  
 City or town Bel Air  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Harford  
 City or town Bel Air, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 136 Maple Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

CATHERINE SECHRIST

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced S  
 6.(b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) Feb 26-1931  
 8. AGE: Years 16 Months 3 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Whitford Md  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Charles J Sechrist

13. Birthplace York Co, Pa

14. Maiden name Mary Ann Stratt

15. Birthplace Whitford Md

16. Informant Chas J Sechrist

Address Bel Air, Md

17. Burial Date thereof June 24/47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Bel Air Burial Park

Location Bel Air Md

18. Funeral director Burg Funeral Home

Address Red Lion Pa OK Drury Foster

19. 6/23 19 47 Priscilla Foust  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 19 47, at P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April, 19 46, to June 20, 19 47.

and that I last saw him alive on June 20, 19 47.

Immediate cause of death Pulmonary Embolism

Due to Congestive Heart Failure

Due to Acute Rheumatic Fever

& Carditis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

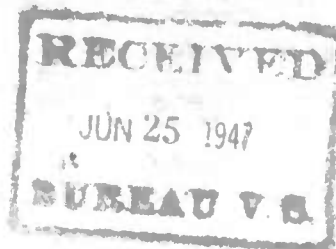
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert A. Barthel M.D.  
 Address Forest Hill Md Date signed 6/24/47

DURATION

immediate  
3 months



## MARYLAND STATE DEPARTMENT OF HEALTH X

2411 N. Charles St., Baltimore

Hod

05188

181

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Harford  
City or town near Bayman, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? about 1 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town near Bayman, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mr. George T. Smith

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife George T. Smith 17th6. (c) If alive, give age 67 years7. Birth date of deceased (mo., day, yr.) Sept. 9 - 18828. AGE: Years 64 Months 9 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harford Co.  
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name John A. Rampton13. Birthplace Harford Co.14. Maiden name Anni Pichie15. Birthplace Harford Co.16. Informant Mr. Geo. T. SmithAddress Bayman, Md.17. Burial Date thereof 6/23/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Angel HillLocation Have the Office18. Funeral director Parrington & SonAddress Have the Office19. June 21 19 47 Nellie Z. Riley  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 26 June 19 47 at 11:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 47 to June 19 47and that I last saw him alive on 19 June 19 47Immediate cause of death Myocardial infarction and carcinoma -  
stomachDue to Cancer of the rectum 6 mm.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations inoperable cancer of the re-  
turn - liver metastasis Date of op. May 20

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel D. Dolse, M.D. M. D. or other \_\_\_\_\_Address 419 Congress Ave Date signed 21 June

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 30 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1008

## CERTIFICATE OF DEATH

05089

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Baltimore Memorial Hospital  
 How long in hospital or institution? 27 hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Chesapeake  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war none

## 3. (a) FULL NAME

Charles S. Stansbury

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Widowed

6.(b) Name of husband or wife Ida Christy7. Birth date of deceased (mo., day, yr.) Dec. 13-1882

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years Months Days If less than one day

64 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Perryman, Harford Co. Md.

(Town, county, and state)

10. Usual occupation Day Laborer

11. Industry or business

12. Name William H. Stansbury13. Birthplace Baltimore Co. Md.14. Maiden name Delia Tildon15. Birthplace Baltimore Co. Md.16. Informant Florence L. JohnsonAddress #5 Bools Court, Harford Co. Md.17. Burial Date thereof June 19-1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union Mt. 2Location Near Chesapeake Md.18. Funeral director Henry FarringtonAddress Chesapeake Md.19. June 18 47 A. L. Lewis Jr.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1947 to June 16 1947and that I last saw him alive on June 15 1947

Immediate cause of death

Phlebitis, Right Femoral Vein, Embolus + Thrombosis

Due to

Due to Cardiac Failure

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

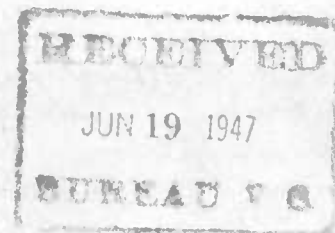
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Kelly M.D.Address Chesapeake Md. Date signed 6/19/47



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05090

Reg. Dist. No. 186

### 1. PLACE OF DEATH:

County Harford

City or town Have de Grace  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:  
835 Erie St.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Have de Grace  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 835 Erie St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Helen Pesco Staubsbury

### 3. (b) Social Security Number

4. Sex Female

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Douglas Staubsbury

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1905

8. AGE: Years 39 Months 4 Days 12 hrs. min.

9. Birthplace Have de Grace, Harford Co., Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James T. Pease

13. Birthplace Have de Grace, Md.

14. Maiden name Aunie Giles

15. Birthplace Perryman, Md.

16. Informant Mrs. Annie G. Johnson

Address 835 Erie St., Have de Grace

17. Burial (Burial, cremation, or removal. Which?) Burial

Location Union M. C. near Aberdeen.

18. Funeral director Henry Lanning & Sons

Address Aberdeen, Md.

19. 6-9 1947 A. S. Lewis D.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 7th 1947 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 April 1947 to 7 June 1947

and that I last saw him/her alive on 7 June 1947

Immediate cause of death Hypertensive pneumo- and chronic myocardial failure

Due to Psychosis

Due to Dementia Praecox

Other conditions Malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel D. Butler

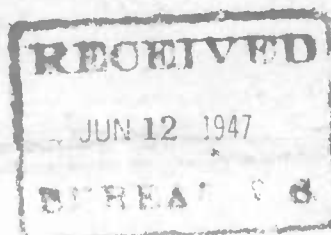
Address 49 Congress Ave. & 1st St. Md.

Date signed 9 Jan 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05091

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County HarfordCity or town Forest Hill  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Forest Hill  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ANNA ISABELLE STONEBRAKER

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S6. (b) Name of husband or wife ✓7. Birth date of deceased (mo., day, yr.) NOV 18-1863 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 83 Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harford  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name John Stonebraker13. Birthplace Pa14. Maiden name Ellen Blakely15. Birthplace Md16. Informant Miss Katherine E StonebrakerAddress Forest Hill, Md17. Buried Date thereof July 1/47  
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory St IgnatiusLocation Hickory, Md18. Funeral director Dean Y FaterAddress Bel Air near19. 6/29 47 Piscilla Louwood  
(Date rec'd by registrar) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at 3:20 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1947 to June 28 1947and that I last saw her alive on June 28 1947Immediate cause of death Lobar pneumonia terminating aDue to Ch Hyperbensive Cardio- vascular disease ?

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, publc place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Willard P Hudson Forest Hill, Md 6/29/47  
M. D. or other \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

JUL 5 1947

BUREAU

Evidence for change of  
surname shown on Film G115

5/12/48 dm Letter from Funeral  
Director.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05092

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford  
City or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 hrs  
Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
How long in hospital or institution? 7 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil  
City or town Port Deposit  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 290 N. Main  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

3. (a) FULL NAME

Charles Joseph Trowbridge

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Armida Trowbridge  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) October 1, 1884  
8. AGE: Years 62 Months 8 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Easton, Md.  
(Town, county, and state)  
10. Usual occupation Engineer  
11. Industry or business Power House  
12. Name Edward Trowbridge Trowbridge  
13. Birthplace Connecticut  
14. Maiden name Mary Jane Radley  
15. Birthplace Maryland

16. Informant Mrs Armida Trowbridge Trowbridge  
Address 290 Main St., Port Deposit, Md  
17. Burial Burial Date thereof June 29, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Hopewell  
Location Port Deposit, Md. Rural

18. Funeral director See A. Patterson & Son  
Address Ferryville, Md.  
19. June 29 19 47 A. L. Lewis  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26 19 47 at 6:04 M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-25 19 47 to 6-26 19 47  
and that I last saw him alive on 6-25 19 47

Immediate cause of death Cerebral Vascular  
Accident  
Due to Hypertensive Cerebro-  
vascular disease.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

19. SIGNATURE W. H. Richard M.D.  
Address Port Deposit, Md Date signed 6-27-47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17006

## CERTIFICATE OF DEATH

05093

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County HartfordCity or town Havre de Grace  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Hartford Memorial HospitalHow long in hospital or institution? 3 days

## 3. (a) FULL NAME

Mr. Edward Volkmer

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Mrs. Julia Volkmer

## 7. Birth date of deceased (mo., day, yr.)

October 9, 1916

## 8. AGE:

30 Years8 Months2 Days

If less than one day

.....hrs. ....min.

## 9. Birthplace

Balto. Md.  
(Town, county, and state)

## 10. Usual occupation

Restaurant Business

## 11. Industry or business

Rest. E. Volkmer

## 12. Name

German

## 13. Birthplace

Calvin W. Schlender

## 14. Maiden name

Balto. Md.

## 15. Birthplace

Julia M. Volkmer

## 16. Informant

719 Brookwood Rd

## Address

Burial

## 17. (Burial, cremation, or removal. Which?)

Date thereof 6/14/47  
(month) (day) (year)

## Cemetery or crematorium

Wesleybridge Mem. Ch.

## Location

Elkridge Md.

## 18. Funeral director

Harry F. Witzke

## Address

4101 Edmondson Ave.

## 19. (Date rec'd by registrar)

6/12 47

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

## State

Md.

## County

Baltimore

## City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

## Street No.

719 Brookwood Rd. Zone 29

(If rural, give LOCATION)

## 2. (a) If veteran, name war

✓ ✓

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

6/11/47 19..... at 9:46 P.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/9 1947 to 6/11 1947and that I last saw him alive on 6/11 1947Immediate cause of death Fracture of 7th cervicalvertebra & contusion and severanceof spinal cord - ParaplegiaDue to and partial quadriplegia

Due to.....

Other conditions Terminal bronchopneumonia

(Include pregnancy within 3 months of death)

## Major findings of operations

..... Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6.9.47Where did injury occur? U.S. Rte 40 1/2 mile north of trafficlight in Aberdeen (City or town) 7/2 (County) (State)Injured at home, farm, industry, public place (where?) public placeMeans of injury Automobile Accident Injured at work? no

## 23. SIGNATURE

John F. Noguera M.D.

M. D. or other

Address Hartford Mem Hosp. Date signed 6.11.47

County  
COPY SENT TO ~~LOCAL~~ REGISTRAR No. \_\_\_\_\_ DATE 7-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

05094

Reg. Dist. No. 182

## 1. PLACE OF DEATH

County Harford  
 City or town B-1-air-  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 hrs + 30 mins  
 Hospital, institution, or street address where death occurred:  
Southern Green Hospital  
 How long in hospital or institution? 5 hrs + 30 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford  
 City or town none  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Carol Louise Ward

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

W -

## 6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

5 hrs. 30 min.

## 9. Birthplace

B-1-air Harford Co. Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER

## 12. Name

James G. Ward

## 13. Birthplace

Harford Co. - Md

## 14. Maiden name

Luth F. Gross

## 15. Birthplace

Harford Co. Md.

## 16. Informant

Mrs James G. Ward

## Address

Forest Hill, Md

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

June 13-47  
(month) (day) (year)

## Cemetery or crematory

Bethel

## Location

Madonna Harford Co Md

## 18. Funeral director

## Address

Charles C. Frost  
Garrettsville Md

## 19.

6/12  
(Date rec'd by registrar)

## 19.

47  
Priscilla Forward

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

JUNE 12 1947 at 9:30 AM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 12, 1947 to JUNE 12, 1947and that I last saw him alive on JUNE 12, 1947

## Immediate cause of death

Prematurity

## DURATION

34 weeks

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

## Means of injury

Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Robert A. Barth

M. D. or other

## Address

Forest HillDate signed 6/12/47

RECEIVED

JUN 17 1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05095

## CERTIFICATE OF DEATH

Reg. Diat. No. 183

## 1. PLACE OF DEATH:

County Harford  
 City or town Upper X Roads  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford  
 City or town Upper X Roads  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Margaret Agatha Watson

## 3. (b) Social Security Number

4. Sex F 5. Color or race w 6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband or wife Gotham E. Watson7. Birth date of deceased (mo., day, yr.) Feb. 22, 18858. AGE: Years 62 Months 3 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Wilks Co. N.C.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Adolphus Blackburn13. Birthplace Wilks Co. N.C.14. Maiden name Lydia Greene15. Birthplace Wilks Co. N.C.16. Informant Russell E. WatsonAddress Benson, Harford Co. Md17. Burial Burial Date thereof June 13, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Upper X Roads BaptistLocation Upper X Roads, Md18. Funeral director Martin D. KirtzAddress Garrythensville Md19. June 13 1947 James R. Brown  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1947 at 8 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1, 1946 to June 10, 1947 and that I last saw him alive on June 10, 1947Immediate cause of death Central Hemorrhage

## DURATION

1 weekDue to Hypertensive Cardio. Vasc. Dis. see youDue to At least 2Other conditions yes, from

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert A. Barthel M. D. or other \_\_\_\_\_Address Forest Hill, Md. Date signed 6/12/47

RECEIVED  
JUL 22 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County... Harford  
 City or town... Bel Air Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 12 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... md County... Harford  
 City or town... Rural - Bel Air  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Mr. Joelson  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Harvey L. Wooden

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced W

6.(b) Name of husband or wife... Lillie T. D. Tzall  
 7. Birth date of deceased (mo., day, yr.) Oct 5/1874 6.(c) If alive, give age... years

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace... Hamstead, Md  
 (Town, county, and state)

10. Usual occupation... Retired

11. Industry or business

12. Name... Louis Wooden  
 13. Birthplace... Md

14. Maiden name... Anna Blizard  
 15. Birthplace... Md

16. Informant... Mrs Margaret Brandt  
 Address... 1833 E 29<sup>th</sup> St Bel Air Md

17. Burial Date thereof... June 27/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... BEL AIR BURIAL PARK  
 Location... BEL AIR, Md

18. Funeral director... Dean & Inlet  
 Address... Bel Air Md

19. 6/26 1947 Purcella Louwood  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 24 1947 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1947 to June 24 1947 and that I last saw him alive on June 19 1947

Immediate cause of death... Ch. Myocardial Disease  
 DURATION >

Due to...

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Willard P Hudson M. D. or other

Address... Forest Hill Md Date signed... 6/25/47

RECEIVED

JUN 30 1947

BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

Reg. Dist. No. 1824

## 1. PLACE OF DEATH:

County HarfordCity or town Charlottesville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3-5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Charlottesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION) ms

2.(c) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

FRANK D. ZELMAN

## 3. (b) Social Security Number

ms4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced WidowerB. (b) Name of husband or wife Mary Zellman7. Birth date of deceased (mo., day, yr.) Feb. 1, 1892 B. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 55 Months 4 Days no It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harford Co., Md.  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business On Farm12. Name John D. Zellman13. Birthplace Germany14. Maiden name Amelia Kirchert15. Birthplace Germany16. Informant Mr. Henry ZellmanAddress Charlottesville, Md.17. Burial June 5, 1947

(Burial, cremation, or other) Date thereof (month) (day) (year)

Cemetery or crematory St. TrinityLocation Harford Co., Md.18. Funeral director H. D. BaileyAddress Charlottesville, Md.19. June 2 19 47 M. H. Kirk

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 1 19 47 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Probable Cerebral Hemorrhage DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. W. Ramsey, M.D.Address Sp. Medical Examiner Date signed 6/2/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

